

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN46962			
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint # IN00097335.</p> <p>Complaint # IN00097335-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 3, 4, 5, 6, & 7, 2011</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Survey team: Vicki Bickel, RN-TC Deanne Mankell, RN Donna M. Smith, RN Tammy Alley, RN Deborah Barth, RN Linn Mackey, RN Toni Maley, BSW</p> <p>Census bed type: SNF: 10 NF: 23 SNF/NF: 111 Residential: 91 NCC: 13 Total: 248</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0241 SS=E	<p>Census payor type: Medicare: 16 Medicaid: 95 Other: 137 Total: 248</p> <p>Sample: 24 Supplemental sample: 1 Residential sample: 10 NCC sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/17/11 by Jennie Bartelt, RN.</p>						
	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interviews and record review, the facility failed to assure residents were treated with dignity by not answering call lights to meet their needs. This affected 6 of 14 residents attending the group meeting had waited longer than 30 minutes at least twice a week in the</p>			F0241	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The President and Vice President of the Resident Council met with Director of Nursing to discuss call light response issues and having their</p>		11/06/2011

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	<p>last three months to have their needs met and 11 of 14 residents in attendance at the group meeting indicated staff had told them there was not enough help. (Residents #601, 602, 603, 605, 607, 608, 609, 610, 611, 612, & 613)</p> <p>Findings include:</p> <p>The group meeting was held on 10/5/11 at 1:30 p.m. There were 14 residents in attendance who had been identified as alert, oriented, and interviewable by the Activity Director at the time the meeting started. The residents included Residents #601, 602, 603, 605, 607, 608, 609, 610, 611, 612, & 613.</p> <p>Residents expressed a concern about not having needs met when using a call light. 6 of 14 residents indicated they had waited longer than 30 minutes to have their needs met after using the call light. 4 of 14 residents indicated the staff would reset the call light, state they would return to meet the residents' needs, but not return. Resident # 610 indicated she had waited 4 hours to receive a pain pill. Resident # 602 indicated he had been told the staff pager was not working. Resident # 607 indicated she had turned her call light and no one had answered it during the night shift. Her needs had been met when the next shift staff person began</p>				<p>needs met on 10/28/2011. The Director of Nursing asked to be allowed to attend the next three resident council meetings and request a time frame for follow up to ensure satisfaction. All staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. All residents were assessed to ensure that their needs were being met. All staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011.</p> <p>3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Call Light P & P was reviewed. All</p>		

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	<p>making rounds. 12 of 14 residents in attendance indicated they knew the facility was short staffed.</p> <p>The residents were asked how they were aware of the need for more staff. 11 of 14 residents in attendance at the group meeting indicated they had been told by staff that there was not enough staff available. Resident # 602 indicated he had observed staff running around trying to get work done, but there was only one CNA available to answer call lights.</p> <p>The Resident Council Meeting minutes were reviewed with the following noted:</p> <p>The Resident Council Minutes for April 20, 2011 indicated, "Concern that there is not enough staff to care for residents. 'CNAs are just stretched to (sic) thin.'" The response (Plan of Action), dated 5/13/11, was "have hired our own CNAs - hiring from a CNA instructor in the area that has specifically recommended Peabody's. More quality CNA's."</p> <p>The Resident Council Minutes for June 15, 2011, indicated, "Tulip Place (Unit Name) RSCs (CNAs) are slow with call light response time. 'Good but no f/u (follow-up)' Call light response time is slow...overall not enough help..." There was no Plan of Action to concerns listed</p>				<p>staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011. All new employees will receive training at new hire orientation that will outline expectations related to call light response. 4.) Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Resident needs being addressed will be added to the nursing QA action plan and will be monitored through daily rounds with interviewable residents being asked if needs are being met. The QA action plan will then be monitored by the IDT leadership team monthly. Monitoring will be on-going</p>		

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	<p>as "1. Call light response time is slow. 2. RSCs say 'we will be right back' then never return...."</p> <p>The Resident Council Minutes for July 20, 2011, indicated, "Call light response time is still slow." There was no response Plan of Action to the concern.</p> <p>The Resident Council Minutes for September 21, 2011, indicated, "Concern with staffing on the floor especially on TP (Tulip Place) & HH (Hawthorne Heights). Call System Review: Reviewed how call light system works and to only push button once or it can reset the call." No Plan of Action was provided in response to the concern.</p> <p>During the environmental tour on 10/6/11 at 9:45 a.m., the call light was observed to be turned on in the beauty shop on the TCU (Transitional Care Unit) east. The Environmental Services Supervisor and Housekeeping Supervisor were in attendance during the environmental tour. CNA # 18 responded to the call light 10 minutes later. The CNA indicated she was alone on the floor because the other CNA had been at lunch. She had been unable to respond to the call light because she was helping another resident.</p> <p>The Director of Nursing was interviewed</p>						

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F0244 SS=E	on 10/6/11 at 3:45 p.m. She indicated there was no tracking to indicate residents' needs were being met, not just call lights reset to respond to the dignity concern of not meeting needs in a timely fashion. She indicated the call light response time was tracked as to when the call light was turned off, but the residents had not been interviewed relative to their needs being met. 3.1-3(t)						
	When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to address the grievances brought to the facility repeatedly concerning slow call light response for 4 of the last 6 months for Resident Council Minutes reviewed affecting the residents who were present at these meetings. There were 11 residents present at the April 20,		F0244	1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The Director of Nursing met with the President and Vice President of the Resident Council to discuss call light response/ grievance issues and having their needs met on 10/28/2011. The Director of		11/06/2011	

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	<p>2011, meeting, 13 residents at the June 15, 2011, meeting, 11 residents at the July 20, 2011, meeting, and 12 residents at the September 21, 2011, meeting. (April, June, July, and September Resident Council Minutes). 6 of 14 residents attending the group meeting had waited longer than 30 minutes at least twice a week in the last three months to have their needs met, and 11 of 14 residents in attendance at the group meeting indicated staff had told them there was not enough help. (Residents #601, 602, 603, 605, 607, 608, 609, 610, 611, 612, & 613)</p> <p>Findings include:</p> <p>The Resident Council Minutes for April 20, 2011, indicated, "Concern that there is not enough staff to care for residents. 'CNAs are just stretched to (sic) thin.'" The response (Plan of Action), dated 5/13/11, was "have hired our own CNAs - hiring from a CNA instructor in the area that has specifically recommended Peabody's. More quality CNA's."</p> <p>The Resident Council Minutes for June 15, 2011, indicated, "Tulip Place (Unit Name) RSCs (CNAs) are slow with call light response time. 'Good but no f/u (follow-up)' Call light response time is slow...overall not enough help..." There was no Plan of Action to concerns listed</p>				<p>Nursing asked to be allowed to attend the next three resident council meetings and request a time frame for follow up to ensure satisfaction. All staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. Administrator will meet with health center social workers to address follow-up on all past and current concerns to ensure closure. SSD's will complete paperwork to assure resident satisfaction with resolutions. All staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011. 3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any</p>		

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	<p>as "1. Call light response time is slow. 2. RSCs say 'we will be right back' then never return...."</p> <p>The Resident Council Minutes for July 20, 2011, indicated, "Call light response time is still slow." There was no response Plan of Action to the concern.</p> <p>The Resident Council Minutes for September 21, 2011, indicated, "Concern with staffing on the floor especially on TP (Tulip Place) & HH (Hawthorne Heights -Unit Name). Call System Review: Reviewed how call light system works and to only push button once or it can reset the call." No Plan of Action was provided in response to the concern.</p> <p>The group meeting was held on 10/5/11 at 1:30 p.m. There were 14 residents in attendance who had been identified as alert, oriented, and interviewable by the Activity Director as the meeting started. The residents included Residents #601, 602, 603, 605, 607, 608, 609, 610, 611, 612, & 613.</p> <p>Residents expressed a concern about not having needs met when using a call light. 6 of 14 residents indicated they had waited longer than 30 minutes to have their needs met after using the call light. 4 of 14 residents indicated the staff would</p>				<p>system changes you made. Grievance P & P was reviewed. Administrator will meet with health center social workers to ensure Grievance P & P is understood and being followed. All staff to be in-serviced on proper communication of concerns related to staffing and determination of having met a resident's needs after answering a call light by 11/06/2011. All new employees will receive training at new hire orientation that will outline expectations related to resident grievances and call light response. 4.) Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Resident grievances and/or needs being met will be added to the nursing and SS QA action plans. The QA action plan will then be monitored by the IDT leadership team monthly. Monitoring will be on-going.</p>		

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	<p>reset the call light, state they would return to meet the residents' needs, but not return. Resident # 610 indicated she had waited 4 hours to receive a pain pill. Resident # 602 indicated he had been told the staff pager was not working. Resident # 607 indicated she had turned her call light and no one had answered it during the night shift. Her needs had been met when the next shift staff person began making rounds. 12 of 14 residents in attendance indicated they knew the facility was short staffed.</p> <p>The residents were asked how they were aware of the need for more staff. 11 of 14 residents in attendance at the group meeting indicated they had been told by staff that there was not enough staff available. Resident # 602 indicated he had observed staff running around trying to get work done, but there was only one CNA available to answer call lights.</p> <p>Residents were asked how many attended the Resident Council Meetings. Only 2 of 14 residents indicated they attended. Other resident responses included: "They talk about the problems, but never do anything." "They said they would work on it (call light response time), but no resolution."</p> <p>The Director of Nursing was interviewed</p>						

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F0314 SS=D	<p>on 10/6/11 at 3:45 p.m. She indicated there was no tracking to indicate residents' needs were being met, not just call lights reset to respond to the dignity concern of not meeting needs in a timely fashion. She indicated the call light response time was tracked as to when the call light was turned off, but the residents had not been interviewed relative to their needs being met.</p> <p>3.1-3(l)</p>						
	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident's intact skin around a pressure</p>			F0314	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the</p>		11/06/2011

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	<p>ulcer was protected from exposure to a debriding agent for 1 (Resident #69) of 2 pressure sore treatments observed in a sample of 24.</p> <p>Findings include:</p> <p>Resident #69's clinical record was reviewed on 10/6/11 at 9:40 a.m. Diagnoses included but were not limited to: alzheimers dementia, hypertension , cerebellar cysts, depression, and peripheral edema.</p> <p>An observation of wound care for Resident #69 was made on 10/4/11 at 3:00 p.m., with Licensed Practical Nurse (LPN) #30 and Qualified Medication Aid (QMA) #31.</p> <p>During the dressing change for the pressure sore, LPN #30 squeezed Santyl (an enzymatic debriding agent) on her clean gloved finger and applied the ointment to the wound. The Hydrogel (a moistureizing agent) gauze was wadded up, placed on the wound and covered with foam tape. QMA #31 attempted to hold the dressing in place, while LPN #30 secured the dressing with roll gauze. The Santyl dressing slipped off the wound, smearing the enzymatic debrider onto healthy tissue. The dressing was slid back to the wound and secured with the roll</p>				<p>deficiency. Resident #69, wound was assessed on 10/5/2011 by licensed nurse and there were no adverse effects from the practice. Nurse observed during this survey (applying the treatment) will receive education on application of treatment and verification of competence and understanding will be completed. All licensed nursing staff to be educated on the use of Santyl for wound care by 11/6/2011. 2.) Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. All other residents with pressure ulcers treatment orders were reviewed. Only one other resident with current Santyl order was found. Assessment was completed with no redness noted to peri wound area. All licensed nursing staff to be educated on the use of Santyl for wound care by 11/6/2011. 3.) Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Wound care P & P was</p>		

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	<p>gauze without the healthy tissue being cleansed.</p> <p>An interview with LPN #30 after the dressing change was completed, indicated she was unaware of the need to apply the Santyl with a cotton tipped swab or the damage the debriding agent could do to healthy skin.</p> <p>The manufacturer's website, www.santyl.com, indicated the ointment should be applied within the wound. Erythema (redness) could occur on the surrounding tissue.</p> <p>The signed physician recapitulation orders for September 2011 indicated, "Santyl et (and) Hydrogel to L (left) heel wound bid (twice a day) until healed."</p> <p>The resident's "Wound/Skin Healing Record" for 4/23/11 identified the left heel wound as 2.3 cm (centimeters) by 3.0 cm, stage 1, wound bed pink/beefy red, and normal surrounding skin.</p> <p>The "Wound/Skin Healing Record, dated 10/3/11, indicated the wound as 0.9 cm by 0.9cm, scant, serous exudate, wound bed slough, and macerated surrounding skin.</p> <p>3.1-40(a)(2)</p>				<p>reviewed. All licensed nursing staff to be educated on the use of Santyl for wound care by 11/6/2011. 4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Wound dressing changes will be added to the Nursing QA action plan and will be monitored by the Clinical Managers, the Director of Nursing and/or designee daily for the first 30 days, followed by weekly for the next 60 and then monthly for the next 90 days. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>		

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observations, record review, and interview, the facility failed to ensure incontinent care was completed in a manner to prevent urinary tract infections (UTI's) for 2 of 4 residents observed during incontinent care (Resident #89 and #114) and to ensure a physician order was obtained to indicate the use of a resident's Foley catheter for 1 of 1 resident reviewed with a Foley catheter (Resident #15) in a sample of 24.</p> <p>Findings include:</p> <p>1. On 10/04/05 from 1:30 p.m. to 2:10 p.m., Resident #114's personal care was observed. After CNA #3 donned a pair of gloves, she was observed to cleanse the residents peri-area in a continuous circular motion starting at the top of the periarea, wiped down 1 side and under the scrotum</p>			F0315	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Residents #114 and 89 were assessed with no infections noted and #15's Foley catheter was removed 10/4/2011with no adverse affect noted. Immediate in-service was conducted by nurse educator for the direct caregivers who were observed by the surveyors on 10/4/2011, educating them on proper peri-care procedures. All residents with Foley catheter orders were reviewed and are current. All residents were assessed on 10/5/2011 for any new s/s of UTI with no signs/symptoms noted.All nursing staff educated on the policy and procedure for proper peri-care for both male and female residents by 11/06/2011 this to include return demonstration for each. All nurses to be educated on Foley catheter policy and procedure by</p>		11/06/2011

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	<p>and up the other side 3 times before she cleaned the penis. After the resident was turned, CNA #3 cleansed the rectal area. As the resident was turned back to his back, CNA #3 and CNA #9 indicated the resident had been incontinent of urine again. As CNA #3 placed a towel over the resident's peri-area, she indicated the resident was still urinating. While CNA #9 left the room to obtain more supplies, CNA #3 was observed to wipe the front peri-area in the same circular motion again and left the towel over the penis. After CNA #9 returned, she was observed to cleanse the peri-area from front to back on each side with no cleansing of the penis or retraction of the foreskin observed. The resident's personal care was then completed. At this same time during an interview, CNA #9 indicated one should wipe down the one side and then down the other side to complete pericare.</p> <p>On 10/03/11 at 2:15 p.m. during an interview, CNA #3 indicated when doing peri-care, one should wipe down 1 side and then the other side before cleansing down the middle.</p> <p>Resident #114's record was reviewed on 10/04/11 at 9:45 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's type dementia, benign</p>				<p>11/06/2011. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. All other residents with indwelling catheters were reviewed to ensure they had a corresponding justified medical diagnosis. All nursing staff educated on the policy and procedure for proper peri care for both male and female residents by 11/06/2011 this to include return demonstration for each. All nurses to be educated on Foley catheter policy and procedure by 11/06/2011. 3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Peri-Care & Foley Catheter P & P was reviewed. All nursing staff educated on the policy and procedure for proper peri care for both male and female residents by 11/06/2011 this to include return demonstration for each. All nurses to be educated on Foley catheter policy and procedure by 11/06/2011. 4.)Describe how the corrective action(s) will be</p>		

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	<p>prostate hypertrophy with bladder outlet obstruction, and renal insufficiency.</p> <p>The physician order, dated 9/20/11, was Omnicef (an antibiotic) 300 milligrams by mouth every day for 10 days for a urinary tract infection.</p> <p>The urine culture, dated 9/16/11, indicated the growth of greater than 100,000 organisms per milliliter of Proteus mirabilis.</p> <p>2. On 10/03/11 from 4:55 p.m. to 5:05 p.m., Resident #89's personal care was observed. CNA #6 indicated the resident had been incontinent of urine and would use the wipes provided by the family for cleansing. After removing the resident's brief, CNA #6 was observed to cleanse only the top of the peri-area, turn the resident, and cleansed the rectal area. The resident was then redressed and transferred to her wheelchair for dinner. At this same time during an interview, CNA #6 indicated she should had cleansed the full peri-area to prevent an odor, skin irritation, and/or UTI (urinary tract infection).</p> <p>Resident #89's record was reviewed on 10/05/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia with delusions and history of</p>				<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Peri care return demonstrations and adherence to Foley catheter policy and procedures will be added to Nursing QA action plan and will be monitored by clinical Managers, DON and/or designee daily for 30 days, weekly for 60 days and monthly for 90 days to ensure the policy and procedure are being followed. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>		

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	<p>UTI.</p> <p>3. The "PERINEAL CARE/FEMALE" policy was provided by the Administrator on 10/05/11 at 8:30 a.m. This current policy indicated the following:</p> <p>"POLICY: Perineal care is done as ordered by a physician, or as indicated by the resident's condition to cleanse the perineum and prevent infections and odors....</p> <p>...PROCEDURE: ...6. Wet one washcloth, apply soap or periwash to cloth and wipe resident from front of perineum to back of perineum (anal area). a. Incontinent wipes may be used in place of soap and water or periwash for routine toileting,...."</p> <p>The "PERINEAL CARE/MALE" policy was provided by the Administrator on 10/05/11 at 8:30 a.m. This current policy indicated the following:</p> <p>"POLICY: Perineal care is done as ordered by a physician, or as indicated by the resident's condition to cleanse the perineum and prevent infections and odors....</p> <p>...PROCEDURE:</p>						

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	<p>.....6. Wet one washcloth, apply soap or periwash to cloth and wipe resident in a spiral motion from the tip of the penis down its length toward the pubic area. If the resident is uncircumcised, retract the foreskin (prepuce) while washing the penis....."</p> <p>4. Resident #15 was identified during the facility tour on 10/3/2011 at 10:35 A.M. with Unit Manager #17 as being readmitted from the hospital after treatment for aspiration pneumonia.</p> <p>Resident #15's clinical record was reviewed on 10/3/2011 at 4:20 P.M.</p> <p>Resident #15's diagnoses included, but were not limited to congestive heart failure, heart disease, dysphagia, aspiration pneumonia with a PEG (percutaneous enterostomal gastrostomy) tube placement.</p> <p>Resident #15's nurses notes dated 10/3/2011 at 12:41 P.M., indicated, ".... Res (resident) has foley catheter (sic) draining clear yellow urine."</p> <p>Resident #15's physician's orders indicated a lack of an order for the reason for the Foley on the transfer form from the hospital or the readmission orders dated 9/30/2011.</p>						

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	<p>Resident #15's clinical record was reviewed again on 10/4/2011 at 9:20 A.M. There was a lack of an order to discontinue the foley, but the nurses' notes indicated 10/4/2011 at 5:45 A.M., "Foley catheter removed tonight d/t (due/to) order to d/c (discontinue).... catheter removed @ 5 am et will monitor for urine output in the next 8 hours...."</p> <p>The nurse practitioner had seen the resident on 10/3/2011 and had written in her notes "D/C (discontinue) Foley cath."</p> <p>Review of the policy for "Insertion of Foley Catheter for Female Resident," dated November 2010, and provided by the DON on 10/7/2011 at 12:35 P.M., indicated, "It is the policy of Peabody Retirement Community to insert Foley catheters ... as well as other conditions as ordered per Nurse Practitioner or Physician."</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p>						

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F0322 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure there was an order for a gastrostomy tube feeding which was infusing and failed to correctly administer medications per the gastrostomy tube for 2 of 3 residents receiving tube feedings and medications through a gastrostomy tube in a sample of 24 (Residents #15 and #59).</p> <p>Findings included:</p> <p>1. During the facility tour on 10/32011 at 10:37 A.M. with Unit Manager #17, she indicated Resident #15 had a g-tube (gastrostomy tube) which had been placed in the hospital. She had returned recently from the hospital with a diagnosis of aspiration pneumonia.</p> <p>Resident #15's clinical record was reviewed on 10/3/2011 at 4:20 P.M.</p> <p>Resident #15's diagnoses included, but</p>		F0322	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Resident #15 G tube orders for Glucerna 1.2 continuous 60ml/hr are on hold at this time, per physician order written 10/14/2011, and receiving regular diet with nectar thick liquids.All licensed staff to be educated on policy and procedure related to ng/g tube medication administration with return demonstrations done by 11/6/2011.</p> <p>2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being</p>		11/06/2011	

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	<p>were not limited to congestive heart failure, diabetes mellitus, anemia, dysphagia, neuropathy, gastritis, and hypertension.</p> <p>Resident #15 was readmitted from the hospital on 9/30/2011 with a diagnosis of aspiration pneumonia.</p> <p>The transfer form from the hospital dated 9/28/2011 in the clinical record indicated: "....NPO (nothing by mouth)....Maintain PEG (percutaneous enterostomal gastrostomy) tube in place. Glucerna (a commercial diabetic feeding) 3/4 strength at 80 ml/hr (milliliters per hour)...."</p> <p>The physician orders transcribed onto the facility order sheet lacked any notation of a tube feeding.</p> <p>The nurses' notes had notations of "Glucerna at 80 ml/hr" on 9/30/2011 at 4:00 P.M. The nurses' notes continued to indicated the Glucerna was infusing at 80 ml/hr or there was a tube feeding infusing at 80 ml/hr.</p> <p>The MAR (medication administration record) for October 2011 indicated, "Glucerna 3/4 strength continuous tube feeding @ 80 ml/hr dated 10/3/11. The record indicated this was started on 10/3/2011 at 6 P.</p>				<p>affected.</p> <p>All residents have the potential to be affected by the alleged deficient practice. All other residents with G-tube physicians orders were checked and are present. All licensed staff to be educated on policy and procedure related to ng/g tube medication administration with return demonstrations done by 11/6/2011. 3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>ng/g tube medication P & P was reviewed.</p> <p>All licensed staff to be educated on policy and procedure related to ng/g tube medication administration with return demonstrations done by 11/6/2011. 4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Proper medication administration through ng/g tube will be added to</p>		

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	<p>The resident was observed lying in bed on 10/3/2011 at 5:05 P.M. She had a tube feeding infusing at 80 ml/hr via a feeding pump. The label on the tube feeding bag indicated the contents of the bag was "Glucerna."</p> <p>LPN #32 was interviewed on 10/3/2011 at 5:10 P.M., she indicated Resident #15's Glucerna had been mixed and started by the night nurse. She said the nurse told her she had mixed 2 cans of Glucerna with 1 can of water. When asked the strength of the Glucerna, she looked for the cans and brought a can of Glucerna which was labeled "Glucerna 1.2 cal." When asked if there was a can of "Glucerna" she indicated the one labeled Glucerna 1.2 was the only one in the building and she thought this was the only strength available.</p> <p>During an interview with Unit Manager #17 on 10/4/2011 at 9:30 A.M., she indicated the resident had the tube feeding when she returned from the hospital and it was continuous. She indicated the staff needed to make she the orders had been taken off the transfer form and followed.</p> <p>The policy for "Tube Feeding via Continuous Pump" was provided by the DON on 10/4/2011 at 11:07 A.M. The</p>				<p>Nursing QA action plan and will be monitored daily for 30 days, weekly for 60 days, and monthly for 90 days by the Clinical Managers, Director of Nursing and/or designee. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>		

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	<p>policy indicated, "....1. Verify that there is a physician's order fro this procedure.... The following equipment and supplies will be necessary when performing this procedure....8. Prescribed enteral feeding.... The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. 2. The amount and type of enteral feeding....</p> <p>2. Resident #59's clinical record was reviewed on 10/5/11 at 1:00 p.m. Diagnoses included, but were not limited to: aphasia, depression, pain, hip fracture, chronic obstructive pulmonary disease, and history of cerebral vascular accident.</p> <p>An observation of med pass was made on 10/4/11 at 3:26 p.m. with License Practical Nurse (LPN) #30. Resident #59 had a Percutaneous Enterostomal Gastrostomy (PEG) tube.</p> <p>The LPN stopped the continuous feeding formula and detached the feeding tube. She then attached a 60 milliliter (ml) syringe barrel to the PEG tube. She flushed the PEG tube with approximately 30 ml of water. The LPN did not check placement of the Peg tube or check for residual. The LPN then poured each medication into the syringe barrel and let drain into the stomach by gravity. She</p>						

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F0328 SS=D	<p>then poured approximately 30 ml of water into the syringe barrel to flush the medications from the PEG tube into the stomach. The tube feeding was then reattached.</p> <p>The facility policy, dated 1/1//05, received and reviewed on 10/5/11, indicated, "8. check stomach for residual feeding to ensure that the resident is tolerating the feeding. 9. check for proper placement of the feeding tube. 12. If administering several medications, administer each one separately, unless specifically directed otherwise. The tube should be flushed with at least 5 ml water between medications."</p> <p>3.1-44(a)(2)</p>						
	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observations, interview, and record review, the facility failed to ensure</p>		F0328	<p>1.)Describe what the facility did to correct the</p>		11/06/2011	

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	<p>oxygen therapy was initiated by licensed staff for 2 of 2 residents (Resident #113 and #117) with continuous oxygen administration in a sample of 24.</p> <p>Findings include:</p> <p>1. On 10/03/11 at 11:35 a.m., Resident #113's transfer was completed per Hoyer lift from the bed to the wheelchair (w/c). CNA #2 was observed to place a filled portable oxygen tank on the back of the resident's w/c. At this same time during an interview, CNA #1 indicated the resident's oxygen liter was at 2 liters per minute per nasal cannula. She was then observed to connect the oxygen tubing to the portable tank and turned the resident's portable oxygen on to 2 liters.</p> <p>Resident #113's record was reviewed on 10/05/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia and coronary artery disease.</p> <p>The physician order, dated 12/24/08, was oxygen per nasal cannula to maintain oxygen saturation greater than 90%.</p> <p>2. On 10/03/11 at 12:15 p.m. during lunch observation, CNA #3 was observed to return with a filled portable oxygen tank and placed in on the back of Resident #117's wheelchair (w/c). As the resident's</p>				<p>deficient practice for each client cited in the deficiency.</p> <p>Residents #113, 117 oxygen saturation and O2 settings were assessed by the licensed nurse with no adverse indication noted. All nursing staff was educated by 11/6/2011 on the policy and procedure related to oxygen administration.2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents receiving oxygen have the potential to be affected by the alleged deficient practice. All residents receiving oxygen had their concentrator and/or portable device checked by a licensed nurse to assure that the doctor's orders were being followed for each individual. All nursing staff was educated by 11/6/2011 on the policy and procedure related to oxygen administration.3.)Describe the steps or systemic changes the facility has</p>		

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F0332 SS=D	<p>nasal oxygen tubing was reconnected to the portable tank, CNA #3 was observed to turn the oxygen on. At this same time during an interview, she indicated she had turned it to 4 liters, which was observed.</p> <p>Resident #117's record was reviewed on 10/05/11 at 2:40 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, dementia, and chronic obstructive pulmonary disease.</p> <p>The physician's order, dated 8/17/11, was oxygen at 4 liters per minute per nasal cannula continuously.</p> <p>3. On 10/05/11 at 4:15 p.m. during an interview, the Director of Nursing indicated CNA's should not be regulating the oxygen flow.</p> <p>3.1-47(a)(6)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a</p>		F0332	<p>made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>Oxygen administration P & P was reviewed and updated.</p> <p>All nursing staff was educated by 11/6/2011 on the policy and procedure related to oxygen administration.4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>O2 administration will be added to the Nursing QA action plan and will be monitored by clinical managers, DON and/or designee daily for 30 days, weekly for 60 days and monthly for 90 days to ensure the policy and procedure are being followed. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p> <p>1.)Describe what the facility did to correct the deficient practice for each client cited in the</p>		11/06/2011	

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	<p>medication error rate of less than 5%, for 2 of 24 sampled residents and for 1 of 1 resident in a supplemental sample observed receiving medications. Three errors in medication administration were observed during 40 opportunities for error in medication administration. This resulted in a medication error rate of 7.5%. (Residents #25, #36, and #86).</p> <p>Findings include:</p> <p>1. During the medication pass observation on 10/03/2011 at 5:15 P.M., Resident #25 was observed being administered 8 units of NovoLog insulin (fast acting insulin).</p> <p>Resident # 25 was observed sitting in her wheelchair in the dining room. She was served her evening meal at 6:02 P.M. and she started eating at that time. This was 47 minutes after the insulin was administered.</p> <p>Resident #25's clinical record was reviewed on 10/5/11 at 1:07 A.M.</p> <p>Resident #25's diagnoses included, but were not limited to, IDDM (insulin dependent diabetes mellitus), hypertension, and peripheral neuropathy.</p> <p>Resident #25's October 2011 Physician's</p>				<p>deficiency. Residents #25, 30, and 86 were assessed by the licensed nurse for any s/s of distress related to the medication errors and none were noted. All licensed nurses/QMAs were educated on administration of Novolog (fast acting insulin) , Symbicort therapy & Carbadopa-levadopa 10/100, per Physician's orders by 11/6/2011. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents receiving Novolog, Symbicort and/or Carbadopa-levadopa have the potential to be affected by the alleged deficient practice. All residents with Novolog orders, Symbicort inhaler orders, and Carbadopa-levadopa 10/100 orders, charts were reviewed to ensure that the Physician's orders for administration are being followed. All licensed nurses/QMAs were educated on administration of Novolog (fast acting insulin) , Symbicort therapy & Carbadopa-levadopa 10/100, per Physician's orders by 11/6/2011.3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient</p>		

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	<p>recapitulation orders indicated "Novolog 100 unit/ml vial. Inject sub-q per sliding scale. < (less than)150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 8 units > (greater than) 400 = 10 units and call MD</p> <p>Resident #25's Glucose Documentation for 10/5/11 at 5 P.M. was 344 and 8 units were administered.</p> <p>Review of the Nursing 2012 Drug Handbook on page 731 for NovoLog insulin indicated "Give NovoLog 5 to 10 minutes before start of meal."</p> <p>2. The record for Resident # 86 was reviewed on 10/5/11 at 2 p.m. The physician orders for October 2011 indicated an order for Symbicort 160/4.5 inhaler, inhale 2 puffs by mouth 2 times daily.</p>			<p><i>practice does not recur , including any in-services, but this also should include any system changes you made.</i> Practices for medication administration of Novolog, Symbicort, and Carbadopa-levadopa were reviewed and updated. All licensed nurses/QMAs were educated on administration of Novolog (fast acting insulin) , Symbicort therapy & Carbadopa-levadopa 10/100, per Physician's orders by 11/6/2011. <i>4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> Medication administration of Novolog, Symbicort, and Carbadopa-levadopa, will be added to Nursing QA Action Plan and will be monitored by Clinical Managers, DON and/or designee daily for 30 days, followed by weekly for 60 days, and then monthly times three months. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>			

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	<p>During medication pass observation on 10/4/11 at 3:40 p.m., QMA (Qualified Medication Aide) # 15 administered Symbicort 160/4.5 inhaler medication to Resident # 86. She administered one puff to the resident, waited 7 second and gave the second puff. The plastic ziplock bag in which the Symbicort was stored had a sticker from the pharmacy that indicated "...wait 1 minute between puffs...."</p> <p>3. Resident # 36's clinical record was reviewed on 10/6/11 at 1:00 p.m.. Diagnoses included, but were not limited to: vascular dementia, Parkinson's disease, hypertension and right sided hemiparsis.</p> <p>The medication pass was observed on 10/4/11 at 10:22 a.m.</p> <p>Licensed Practical Nurse (LPN) #30 placed the carbadopa-levadopa (Parkinson's medication) in a small plastic cup. The LPN carried the medication and a small glass of water into the resident's room. She gave the resident the medication cup and after the resident placed the pill in her mouth, she gave the resident a drink of water. The resident was not observed eating any food at this time. LPN #30 continued to pass medications.</p> <p>The signed physician recapitulation orders</p>						

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F0371 SS=E	<p>for the month of September 2011, indicated a physician's order for "Carbadopa -levadopa 10/100 milligrams TID (three times a day) with meals."</p> <p>The dining room for this unit was not opened until 11:45 a.m.</p> <p>During an interview on 10/7/11 at 10:00 a.m., the Director of Nursing indicated she was not aware the carbadopa-levadopa was to be given with meals.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observations, record review, and interviews, the facility failed to ensure a clean and sanitary environment related to the dishmachine, handwashing and glove</p>			F0371	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the</p>		11/06/2011

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	<p>use, and hair covering for 2 of 5 kitchens (Memory Care and Evergreen Park/Willow Way) observed. This had the potential to affect 23 residents in Memory Care and 40 residents in Evergreen Park/Willow Way (Health Care North) of 144 residents in the facility.</p> <p>Findings include:</p> <p>1. On 10/03/11 from 5:40 p.m. to 6:05 p.m., the following was observed in the Evergreen Park/Willow Way kitchen:</p> <p>Dietary Aide #20 with no hair net on was observed preparing dessert bowls of peaches and grapes. At this same time during an interview, Dietary Aide #20 indicated he needed to go get a hair net and proceeded to put it on. After taking the prepared desserts on the cart out to the dining room, Dietary Aide #20 returned to the kitchen area and prepared and took out the cart with the pitchers of drinks on a cart. No handwashing was observed.</p> <p>Cook #21 was observed to handwash for 15 seconds and donned a pair of gloves as he proceeded to mix up the mashed potatoes. Next, as he was finished checking the food temperatures, he was observed to wipe his gloved hand on the side of his shirt followed by stirring the mashed potatoes and checking the</p>				<p>deficiency.</p> <p>An immediate in-service was conducted with all dietary staff to address both hand washing and hairnet issues. There were no residents adversely affected by the deficient practice. All staff were re-educated on the hand washing policy and procedure and proper use of hairnets by 11/6/2011. 2.) Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents have the potential to be affected by the alleged deficient practice. After review, no residents were affected by the deficient practice..</p> <p>All staff were re-educated on the hand washing policy and procedure and proper use of hairnets by 11/6/2011. 3.) Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services,</p>		

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	<p>temperature. After he removed his gloves, he checked the diet slips, handwashed for 10 seconds, and donned another pair of gloves. Then, he rechecked the mashed potatoes on the stove and wiped his gloved hand on his shirt. Then, with the same gloved hands he picked up a plate, removed 2 slices of bread placing them on the plate, scooped up ham salad and placed it on one slice of bread. With the same gloves he continued to place the 2nd piece of bread on top of the ham salad followed with the garnishes, which were tomato, onion and lettuce, with a pair of tongs. The plate was placed on top for serving. With the same gloves Cook #21 continued to pick up a plate, followed by 2 pieces of bread on the plate, a scoop of ham salad on 1 slice with the 2nd slice placed on top of the ham salad. The same forceps were then used to place the garnish on the plate as the plate was ready to be served.</p> <p>Dietary Aide #20 was observed to return to the kitchen, handwashed for 12 seconds, returned to the dining room, and began to serve the prepared plates to the residents. When a serving of salad dressing was requested for a room tray, Dietary Aide #20 returned to the kitchen. No handwashing was observed. He was observed to go the refrigerator, obtained the large container of salad dressing and</p>				<p>but this also should include any system changes you made.</p> <p>Handwashing, Uniform Dress Code and Infection Control P & P were reviewed.</p> <p>All staff were re-educated on the hand washing policy and procedure and proper use of hairnets by 11/6/2011. 4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Hand washing and hairnet usage will be added to the Dietary and Nursing QA action plans. Each dining manager has been assigned two kitchens to conduct audits two times daily for the next 30 days, two times weekly for 60 days, and at least once a week for next 90 days. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>		

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	<p>small serving container, and prepared the serving of salad dressing. He then was observed to handwash for less than 10 seconds and returned to the dining room and continued to serve the prepared meal plates.</p> <p>LPN #5 was observed to enter the kitchen with a hair net on. The bottom half of her long shoulder length hair was not covered by the hairnet as she was observed to get ice from the ice machine. No handwashing was observed.</p> <p>As Cook #21 ran out of bread, he was observed to obtain a new loaf from a cabinet. Next, he removed his gloves, handwashed for less than 15 seconds, donned a new pair of gloves, and returned to serving dinner as before with the same gloves on for each resident's plate. At this same time during an interview, Cook #21 indicated he was serving for 40 residents.</p> <p>A sign was observed posted at the handwashing sink indicating one should handwash for 20 seconds.</p> <p>2. On 10/03/11 from 6:40 p.m. to 6:55 p.m., the following was observed in the Evergreen Park/Willow Way kitchenette:</p> <p>As Dietary Aide #20 was running the dishwasher, the rinse cycle temperature</p>						

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	<p>reading was observed to be "P2" with no temperature reading given 3 different times. The second load observed had the wash temperature ranging from 145 to 148. At this same time during an interview, Dietary Aide #20 indicated there had been a few problems with the dishwasher with no specifics given. He also indicated the wash temperature should be at 150 degrees or higher with the rinse cycle at 180 degrees or higher.</p> <p>3. On 10/03/11 from 9:30 a.m. to 9:40 a.m., the following was observed in the Evergreen Park/Willow Way kitchen:</p> <p>Dietary Aide #22 was observed to remove her gloves and handwashed for less than 20 seconds. She then proceeded to check the dishes in the dishwasher as the cycle was completed. As she indicated she needed to record the rinse temperature, she restarted the dishwasher. When the dishwasher indicated the rinse cycle, no temperature reading was observed. Cook #22 ran the dishwasher 2 more times with the same result of no rinse temperature observed. At this same time during an interview, she indicated she had problems with the dishwasher before and was not sure what the problem was as the dishwasher had worked correctly for her yesterday. Also, Dietary Aide #22 indicated one should handwash after</p>						

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	<p>saying the ABC's 1 time, which she thought was 60 seconds, and one should handwash between tasks.</p> <p>4. On 10/06/11 at 10:05 a.m. during an interview, Cook #23, who indicated she was in charge of this kitchen, indicated one should handwash between tasks and after touching one's face, for example. Also, one should handwash for 20 seconds, and hair nets should cover 90% of ones hair when in the kitchen. While serving the meal, one should change gloves or use tongs, for example, when serving bread for sandwiches for each resident. She indicated she had reported the dishwasher not working Tuesday at the end of her shift.</p> <p>On 10/06/11 at 10:40 a.m. during an interview, the Dietary Manager indicated the dishwasher should had been reported for repairs on Monday at dinner time when no rinse temperature was indicated.</p> <p>5. The "Dishmachine Temperature Log (High Temp)" for 10/11 indicated no information for the 10/01 and 10/02 for breakfast, lunch, or dinner. The lunch temperature for 10/05 indicated the dishmachine was "out of order."</p> <p>6. The "Dishwashing" policy was provided by the Dietary Manager on</p>						

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	<p>10/06/11 at 10:35 a.m. This current policy indicated the following:</p> <p>"...Machine Washing: ...5. Dishmachine temperatures are logged at each meal on the [Dishmachine Temperature Log] a. Memory/HCN (Health Care North)/HCS (Health Care South): Minimum temperatures, as required by the manufacturer, are Wash 150-160 Final Rinse 180-195 F (Fahrenheit) ...7. Report any temperature outside the acceptable range to manager immediately; manager or designee will notify maintenance"</p> <p>6. During a kitchen observation on the memory care unit on 10/3/11 between 11:40 a.m. and 12:40 p.m., the following was observed. At 12:10 p.m., Cook # 11 poured puree food from styrofoam bowls into divided plates. He then washed his hand for 10 seconds, turned off the water with his wet hands, dried his hands and then went back to pouring the pureed food into divided plates. He then began plating food for service.</p> <p>At 12:20 p.m., Dietary Aide # 12 washed her hands for 12 seconds. She then retrieved a pie server and knife from a drawer, the pie from the refrigerator, and plates from under the counter and placed</p>						

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	<p>them on the preparation counter. She donned gloves and removed the plastic wrapper from the pie and removed the plastic lid. She cut the pie and placed onto plates. She then removed her gloves and retrieved another pie from the refrigerator, placed it on counter, removed the plastic wrap and plastic lid from the pie. She cut the pie with a knife and plated the pie with the pie server and used her gloved left hand to slide the pie onto the plate. She then carried a tray of plated pie to the serving area. She returned to the preparation counter and continued to plate the pie with the same gloved hands, sliding the pie onto the plate with her gloved left hand. She then retrieved another pie from the refrigeration, using the same gloved left hand she open the plastic wrapper and cover on the pie. She then cut the pie and plated the pie in the same manner as above, using her left gloved hand to slide the pie onto the plate. She removed the glove to her left hand and carried the tray of plated pie to the serving area. She then washed her hands for 5 seconds. After the dried her hands, her used paper towel fell onto the floor by the trash can, she then picked up the paper towel and placed it in the trash. She again washed her hands for 10 seconds. She retrieved plates and placed them on the preparatory counter. She then donned gloves and continued to plate the pie by</p>						

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	<p>using her left gloved hand to slide the pie onto the plate. She then carried the tray of plated pie to the serving area. She removed her gloves and began placing the puree pie from styrofoam bowls into bowls for serving and carried them to the serving area. During this observation, a sign was observed taped to the paper towel holder above the sink that indicated hand washing should be for 20 seconds.</p> <p>7. A policy titled "Hand Washing" was provided by the Administrator on 10/5/11 at 8 a.m., and deemed as current. The policy indicated "...1. When to wash hands: Immediately before engaging in food preparation including working with exposed food, clean equipment or service utensils and :...During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination with changing tasks...Before putting on single-use or durable non-absorbent gloves for working with food or clean dishes...After removing gloves...2. How to wash hands 1. Wet your hands with running water as hot as you can comfortably stand...vigorously scrub hands and arms for 20 seconds...Dry hands and arms with a paper towel. Use the paper towel to turn off the faucet and to open the rest room...."</p> <p>8. A policy titled "Dress Code" was</p>						

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F0406 SS=D	<p>provided by the Administrator on 10/5/11 at 8 a.m., and deemed as current. The policy indicated: "...18...b. Food and Beverage employees must wear a hair net or approved hat while serving food and in the food preparation area..."</p> <p>3.1-21(i)(3)</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to obtain recommended mental health rehabilitative services for mental illness, for 1 of 2 residents reviewed who have mental illness in a sample of 24 (Resident #16).</p> <p>Findings include:</p> <p>1. During the facility tour on 10/3/2011 at 10:30 A.M. with LPN #13, she indicated Resident #16 was mentally retarded.</p>		F0406	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Resident #16's OBRA's preadmission screening recommendations will be followed up upon resident's return to facility.</p> <p>All SS staff was educated on the new policy related to admitting residents with MR or a developmental disability 11/6/2011.</p> <p>2.)Describe how the facility reviewed</p>		11/06/2011	

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	<p>Resident #16's clinical record was reviewed on 10/3/2011 at 2:45 P.M.</p> <p>Resident #16's diagnoses included, but were not limited to, cerebral palsy, hypertension, left sided paresis, bilateral deep vein thrombosis, depression, and a knee replacement.</p> <p>Resident #16's clinical record had a packet of information from the "Office of Medicaid Policy and Planning" dated 6/20/2011 sent to Peabody after the resident had been admitted to Pebody Retirement Community on 6/17/2011. The packet contained the following information:</p> <p>An "OBRA (Ominbus Budget Reconciliation Act) pre-admission screening case analysis" dated 1/15/11 with recommendations of "....5. (Name of resident) will benefit from residential services that will provide her with support and training in a safe and caring environment with access to supervision until she had regained her previous level of functioning. 6. (Name of resident) needs continued opportunities to participate in community-based leisure activities with her peers so that she can develop and enhance her social skills. It will be important to continue these activities following her return home...."</p>				<p><i>all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</i></p> <p>All residents have the potential to be affected by the alleged deficient practice. All other residents charts were audited and all recommendations for mental health rehabilitation services have been completed for appropriate residents 10/24/2011.</p> <p>All SS staff was educated on the new policy related to admitting residents with MR or a developmental disability 11/6/2011.<i>3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</i></p> <p>A new policy related to admitting residents with MR or a developmental disability was developed & reviewed.</p> <p>All SS staff was educated on the new policy related to admitting residents</p>		

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	<p>A Psychological Report dated 1/15/2011 with the a recommendation of ".... 2. (Name of resident) would benefit from a psychiatric evaluation to determine if her depression is situational or represents a chronic condition. This should be followed by counseling and medications as deemed appropriate and necessary. It is suggested that therapy in a cognitive modality would be most effective for (Name of resident)...."</p> <p>During an interview with the SSD on 10/5/2011 at 1:55 P.M., he indicated he was not aware of the recommendations and so the facility had not followed the recommendations.</p> <p>3.1-23(a)(1) 3.1-23(a)(2)</p>			<p>with MR or a developmental disability 11/6/2011.4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>MR admission requirements will be added to the SS QA action plan and will be monitored by the Director of Social Services and/ or designee through admission chart audits to be completed within 72 hours of admission and continuing for next six months. Any OBRA preadmission recommendations will be addressed.. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>			

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F0425 SS=E	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure pharmacy services were provided to ensure medications were available for administration for 4 of 7 residents reviewed for medication availability in a sample of 24. (Resident #204, # 206, # 15 and # 110)</p> <p>Findings include:</p> <p>1. The record for Resident # 204 was reviewed on 10/3/11 at 3:10 p.m.</p> <p>A 6/9/11 physician order indicated an order to change potassium to 10 milliequivalents liquid form everyday.</p> <p>The June 2011 Medication Administration</p>			F0425	<p>1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Residents #204, 206, 15, 110 medications are all available and are being administered per Physician's orders as of 10/25/2011. All licensed nurses and QMAs will be educated on policy and procedure for unavailable medications by 11/6/2011. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. All resident's</p>		11/06/2011

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	<p>Record (MAR) indicated the liquid form of potassium was not available from the pharmacy 6/10/11-6/14/11. The MAR on 6/10/11 indicated the potassium was not available. The MAR on 6/11/11 indicated the potassium was not available and the pharmacy was notified.</p> <p>During interview on 10/5/11 at 9:30 a.m., LPN # 14 indicated the potassium liquid was a non-covered item for payment and was not obtained from the pharmacy. The potassium liquid was changed back to capsule form on 6/15/11 with instructions to open and sprinkle.</p> <p>2. The record for Resident # 206 was reviewed on 10/4/11 at 10 a.m.</p> <p>Current diagnoses included, but were not limited to Gastrointestinal Bleed.</p> <p>A physician order dated 7/8/11 indicated to increase Ferrous Sulfate 325 milligrams one daily three times daily.</p> <p>The July 2011 MAR indicated the Ferrous Sulfate was not available for administration on 7/13, 7/14, for three doses and on 7/15/11 for two doses. The back of the MAR indicated on 7/13/11 the Ferrous Sulfate was not available and the pharmacy was aware. The back of the MAR indicated on 7/14/11 the Ferrous</p>				<p>medications availability were reviewed and were found to be available as of 10/25/211. All licensed nurses and QMAs will be educated on policy and procedure for unavailable medications by 11/6/2011. 3.) Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Policy & Procedure for unavailable medications was reviewed. All licensed nurses and QMAs will be educated on policy and procedure for unavailable medications by 11/6/2011. 4.) Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Medication availability will be added to the nursing QA action plan and MARs and TARs will be reviewed by Clinical Managers, DON and/or designee daily for 30 days, weekly for 60 days and monthly for 90 days. Monitoring will be reviewed in QA meetings and will continue until 100% compliance for 2 consecutive months.</p>		

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	<p>Sulfated was not available and the pharmacy was aware.</p> <p>On 10/5/11 at 9:30 a.m., during interview, LPN # 14 provided a fax confirmation dated 7/8/11 that indicated the pharmacy received the order for the increase in the Ferrous Sulfate. The LPN indicated the Ferrous Sulfate was not obtained from another source.</p> <p>3. Resident #15's clinical record was reviewed on 10/3/2011 at 4:20 P.M.</p> <p>Resident #15 was readmitted from the hospital on 9/30/2011 with diagnosis of aspiration pneumonia.</p> <p>Resident #15's MAR (Medical Administration Record) for October 2011.</p> <p>There was an order for "Clindamycin HCl (antibiotic) cap (capsule) 300 mg (milligrams)-g-tube tid (three times a day) q (every) d (day) x 5 days."</p> <p>This medication was circled as not given on 10/1/2011 at 8AM and 12PM. The back of the MAR indicated the Clindamycin was "not given nurse aware."</p> <p>There was an order for "Levaquin (antibiotic) 500 mg (milligrams) g tube X's 4 days."</p>						

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	<p>This medication was circled as not given on 10/1/2011 at 8A. The back of the MAR indicated the Levaquin was "not given nurse aware."</p> <p>There was an order for "Vasotec (blood pressure medication) 25 mg. i (one) po (by mouth) qd (every day) G-tube.</p> <p>This medication was circled as not given on 10/1/2011 at 8 AM. The back of the MAR indicated the Vasotec was "not given-nurse aware."</p> <p>There was an order for "Docusate Sodium Liquid (laxative)" 150 mg/15 ml. (milliliters). 30 ml. G-tube q.d. [daily] 30 ml. G-tube."</p> <p>This medication was circled as not given on 10/1/2011 and 10/2/2011 at 8 AM. The back of the MAR indicated the Docusate Sodium Liquid was "not given nurse aware" on 10/1/2011 and "not given has been ordered" on 10/2/2011.</p> <p>During an interview with the QMA#15 on 10/4/2011 at 9:55 A.M., she indicated she "didn't give the medications because we didn't have them."</p> <p>During an interview with the Unit Manager #17 at 10:00 A.M., she indicated</p>						

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	<p>the pharmacy should have sent the medications to the facility, but they were not available.</p> <p>4. Resident #110's record was reviewed on 10/04/11 at 3:30 p.m. The resident's diagnoses included, but were not limited to, hypertension, hypokalemia, and dementia with psychosis.</p> <p>The physician's order, dated 3/07/11, was potassium chloride (KCL) give 15 milliliters (20 Milliequivalents) orally 2 times a day.</p> <p>The physician order, dated 7/11/11, was cleanse right side of face and ear lesions (shingles)daily with normal saline then apply calamine lotion and dry dressing daily until healed.</p> <p>The "MEDICATION ADMINISTRATION RECORD (MAR)" for 9/2011 indicated the medication, KCL was not given from 9/09/11 at 4 p.m. through 9/14/11 at 4 p.m., inclusive. The information on the back of this MAR indicated on 9/10/11 at 7 a.m. and at 4 p.m. and on 9/14/11 (no times specified) the medication was not available from the pharmacy with nursing aware. No further information was indicated for 9/09 at 4 p.m., 9/11, 9/12, and 9/13.</p> <p>The MAR for 7/2011 indicated the</p>						

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	<p>Calamine lotion was not given on 7/13, 7/14, 7/16, 7/17, 7/19, and 7/20 with no information indicated for 7/11, 7/12, 7/15, and 7/18/11. The areas were indicated as shingles. The information on the back of the MAR indicated no calamine lotion was available on 7/16 for 6 a.m. to 6 p.m.; on 7/17 for 6 a.m. to 6 p.m. with the order refaxed to the pharmacy, and on 7/20 for 6 a.m. to 6 p.m., the pharmacy stated the lotion was non-covered; an order was received to discontinue the lotion due to unavailability, and area was healing.</p> <p>On 10/06/11 at 1:55 p.m. during an interview, LPN #10 indicated when a medication was not received from pharmacy, the pharmacy should be contacted to determine the problem.</p> <p>5. A policy titled "Vendor Pharmacy Agreement" was provided by the Director of Nursing on 10/5/11 at 3:47 p.m., and deemed current. The agreement indicated "...D. Provide 24-hour emergency coverage seven (7) days a week either by staff of Pharmacy or a local backup pharmacy mutually acceptable to both parties.</p> <p>3.1-25(a)</p>						

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, record review, and interviews, the facility failed to ensure effective infection control practices related to equipment use, linen handling, and handwashing/glove use were</p>			F0441	<p>441 – a 1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Residents #113, 114, 73 and 89 were assessed and had no signs</p>		11/06/2011

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	<p>implemented, which included personal care/transfer for 4 of 6 residents observed (Resident #'s 113, 114, 73, and 89) for 5 of 9 CNA's observed (CNA #'s 1, 6, 3, 9, and 33), scissor handling during 1 of 2 dressing changes observed (Resident #114), for 1 of 2 nursing staff observed (LPN #10), linen handling during personal care for 1 of 4 residents observed (Resident #114) for 2 of 4 CNA's observed (CNA's # 3 and 9), and during dining room assistance for 3 of 12 nursing staff (LPN #5 and #7; CNA #6). This had the potential to affect 3 (Residents #115, 85, and 93) of 63 residents in 2 of 8 dining room areas observed</p> <p>Findings include:</p> <p>1. On 10/03/11 from 11:35 a.m. to 11:50 a.m., Resident #113's transfer and personal care were observed. After CNA #1 with gloved hands completed the transfer per Hoyer lift from the bed to the wheelchair (w/c), CNA #1 repositioned the resident in her w/c. After removing her gloves, CNA #1 was observed to handwash for less than 10 seconds (secs), turned the water off with her wet hands, and then dried her hands. After donning a new pair of gloves, CNA #1 combed the resident's hair and completed her personal care. She then removed her gloves and handwashed for 10 secs, turned the water</p>				<p>and symptoms of infection at this time.Immediate in-service was conducted by nurse educator for the direct caregivers who were observed by the surveyors on 10/4/2011, educating them on proper peri care procedures and linen handling. All residents were assessed on 10/5/2011 for any new s/s of infection with no signs/symptoms noted. All nursing staff educated on the policy and procedure for proper peri care for both male/ female residents, Cath care, and proper linen handling by 11/06/2011 to include return demonstration for each. 2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. All nursing staff educated on the policy and procedure for proper peri care for both male/ female residents, Cath care, and proper linen handling by 11/06/2011 to include return demonstration for each.</p> <p>3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any</p>		

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	<p>off with her wet hands, and dried her hands.</p> <p>2. On 10/03/11 from 12:32 p.m. to 1:05 p.m. during lunch observation, LPN #5 was observed to pick up soiled dishes from a resident's table and placed them in the soiled dishes area. She then obtained a piece of pie from the dessert tray and gave it to Resident #115 as she continued to check on the residents in the dining room passing the pie dessert. No handwashing or use of handgel was observed.</p> <p>On 10/04/11 at 11:15 a.m. during an interview, LPN #5 indicated one should handwash for 20 seconds. She also indicated one should handwash between residents.</p> <p>3. On 10/03/11 from 4:55 p.m. to 5:05 p.m., Resident #89's personal care was observed. CNA #6 indicated the resident had been incontinent of urine. After removing the resident's brief, CNA #6 with gloved hands was observed to complete the resident's peri-care, removed her gloves, assisted in redressing the resident, and transferred her per stand up lift from her bed to the wheelchair. CNA #6 then took the resident to the dining room. No handwashing/handgel use was observed.</p>				<p>system changes you made. A new policy related to admitting residents with MR or a developmental disability was developed & reviewed. All nursing staff educated on the policy and procedure for proper peri care for both male/ female residents, Cath care, and proper linen handling by 11/06/2011 to include return demonstration for each.</p> <p>4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring of peri care and linen handling provided to residents by staff will be completed weekly times one month and then monthly times twelve months by clinical managers, DON and/or designee.441 – b 1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #114 pressure ulcer on his rt heel was assessed on 10/06/2011 with no s/s of infection. All licensed nurses educated on policy and procedure for dressing changes by 11/6/2011.2.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All</p>		

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	<p>4. On 10/03/11 from 6:05 p.m. to 6:45 p.m.. during dinner, the following was observed.</p> <p>LPN #7 was observed to handwash for 15 seconds. LPN #7 then left the dining room and returned with Resident #85 as her meal tray was ready. She then served her meal tray to her as she continued to check with other residents in the dining room. No further handwashing/handgel use was observed.</p> <p>CNA #6 was observed to handwash for less than 10 seconds. She then started feeding Resident #93 his meal.</p> <p>5. On 10/04/05 from 1:30 p.m. to 2:10 p.m., Resident #114's transfer and personal care was observed. After the Hoyer sling was hooked to the Hoyer lift, CNA #3 and CNA #9 with gloved hands began the transfer from his wheelchair to his bed when the Hoyer lift quit working. CNA #3 indicated the battery to the Hoyer lift needed to be changed as she left the room with gloved hands and the battery. She then returned with a different battery with the same gloved hands. After the transfer was complete, CNA #3 removed her gloves and donned a new pair. As CNA #3 reapplied the resident's left arm geri-sleeve and prepared the washcloths,</p>			<p>residents with pressure areas have the potential to be affected by the alleged deficient practice. All residents with pressure ulcer dressing changes assessed for s/s of infection 10/16/2011 with none noted. All licensed nurses educated on policy and procedure for dressing changes by 11/6/2011. 3.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Policy & Procedure for wound care and dressing changes was reviewed. All licensed nurses educated on policy and procedure for dressing changes by 11/6/2011. 4.)Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring of dressing changes will be completed weekly times one month and then monthly times twelve months by clinical managers, DON and/or designee. 441 – c 1.)Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Residents # 115, 85, 93 experienced no negative outcome related to nurse failing to wash hands between handling of soiled dishes and delivery of food. All</p>			

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	<p>CNA #9 was observed to remove her gloves and left the room to obtain more linen. CNA #9 then returned and donned a new pair of gloves and wiped the resident's face and hands off. CNA #3 was then observed to complete the residents peri-care. After the resident was turned, CNA #3 cleansed the rectal area with brown smeared bowel movement observed several times on the washcloths before drying the rectal area. As the resident was turned back to his back, CNA #3 and CNA #9 indicated the resident had been incontinent of urine again. CNA #3 removed the soiled towel from the bag and placed it over the resident's peri-area. She indicated the resident was still incontinent of urine as she wiped the front peri-area and left the towel over the area. Next, CNA #9 removed her gloves and left the room to obtain more linen. After CNA #9 returned, she was observed to don a new pair of gloves and completed peri-care. During this observation CNA #3 with the same gloved hands was observed to check her pager in her uniform pocket 2 times and reset it. With same gloved hands CNA #9 and CNA #3 completed the resident's personal care and positioned him in his bed after removing the wet incontinent pads and bottom sheet with clean linen. Then, CNA #3 was observed to place the soiled bed linen on the floor</p>				<p>staff will be re-educated on policy and procedure for proper handwashing technique and risk of cross-contamination by 11/6/20112.)Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. The 63 residents who eat in that dining room were monitored for possible adverse reaction related to absense of hand washing and none was noted.All staff will be re-educated on policy and procedure for proper handwashing technique and risk of cross-contamination by 11/6/20113.)Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Policy & Procedure for handwashing and infection control were reviewed. All staff will be re-educated on policy and procedure for proper handwashing technique and risk of cross-contamination by 11/6/20114.)Describe how the corrective action(s) will be</p>		

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	<p>as she retrieved a bag and placed the linen in the bag and left the room with it. No handwashing/handgel use was observed. After CNA #3 returned to the room with more linen, she donned a new pair of gloves. Another cloth incontinent pad was positioned under the resident, and the towel over the resident's peri-area was removed by CNA #3. CNA #3 was then observed to handwash for 15 seconds, turn the water off with her wet hand, and dried her hands. Next, as the resident's lower legs/heels were repositioned with pillows, the pillows were held up against both CNA #3 and CNA #9's uniforms before putting the pillows in place. CNA #3 then left the room as CNA #9 cleaned up the room.</p> <p>On 10/03/11 at 2:15 p.m. during an interview, CNA #3 indicated one should handwash for 15 to 20 seconds. She also indicated one should handwash after care, after gloves were removed, and after completing peri-care. At this same time, CNA #3 indicated one should not put linen on the floor or hold soiled linen up to one's uniform.</p> <p>6. On 10/05/11 from 10:00 a.m. to 10:05 a.m., Resident #114's right heel dressing change was observed. LPN #10 was observed to cut the soiled dressing off of the right heel and placed the used scissors</p>				<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Meal service will be monitored by leadership team daily for one month, alternating between all three meals to ensure hand washing is occurring as directed. Monitoring will continue weekly by either leadership member or dietary designee. Monitoring will be on-going. Addendum 11/2/2011: All cited tags will be monitored/observed on all three shifts as indicated.</p>		

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	<p>on the bedside table. During this treatment, the same scissors were used to cut the 4 corners of the foam dressing for a better fit over the heel. After the foam dressing was applied to the right heel, LPN #10 wrapped the heel with gauze using the same scissors to cut the gauze before taping and dating the dressing. After the dressing was completed, LPN #10 was observed to return the unused dressing supplies, Santyl tube, and scissors to the plastic bag and then to the treatment cart. At this same time during an interview, LPN #10 indicated she should have cleansed the scissors with alcohol before placing them into the plastic bag. After she was observed to cleanse the scissors with an alcohol swab, she returned the scissors to the same plastic bag. No handgel/handwashing use was observed after the treatment was completed as she left the room.</p> <p>7. The "Handwashing/Hand Hygiene" policy was provided by the Administrator on 10/05/11 at 8:30 a.m. This current policy indicated the following:</p> <p>"Highlights Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation ...When to Wash Hands</p>						

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	<p>...5. Employees must wash their hands for at least fifteen (20) (sic) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <p>...c. Before and after direct resident contact...</p> <p>...f. Before and after assisting a resident with personal care...</p> <p>...k. Before an after changing a dressing;</p> <p>l. Upon and after coming in contact with a resident's intact skin...</p> <p>...r. After handling soiled or used linens, dressings...</p> <p>s. After handling soiled equipment or utensils;</p> <p>...u. After removing gloves...</p> <p>...Procedure</p> <p>...Washing Hands</p> <p>...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (20) (sic) seconds...</p> <p>...3. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to the inside of sink.</p> <p>4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.</p> <p>5. Discard towels into trash....."</p> <p>8. Resident #73's clinical record was reviewed on 10/4/11 at 2:00 p.m. Diagnoses included, but were not limited to: diabetes mellitus, anxiety, chronic</p>						

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	<p>obstructive pulmonary disease, congestive heart failure, coronary artery disease, and chronic kidney disease.</p> <p>Peri-care, provided by CNA #33, was observed on Resident #73 on 10/4/11 at 10:50 a.m.</p> <p>While the resident was standing with the stand-up lift, the CNA, with gloved hands and a soapy cloth, washed from front to back of the perineal area but did not spread the labia. She removed a pair of gloves after each stroke (3) of washing. She cleaned the buttocks with a soapy cloth using a bare right hand. She also applied a skin protectant, on a cloth, using a bare hand. The CNA then washed her hands.</p> <p>Immediately, after the observation on 10/4/11 at 11:10 a.m., an interview with CNA #33 indicated she had 3 pairs of gloves on initially. She further indicated she did not wash her hands after cleaning the perineal/buttocks area and applying the skin protectant.</p> <p>3.1-18(l) 3.1-19(g)(1)</p>						

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